THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
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August 30, 2002

TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

Jonathan E. Fielding, M.D., M.P.H.
Director of Public Health and Health Officer

SUBJECT: **TESTING OF WATER AT DHS HOSPITALS AND THE HALL OF ADMINISTRATION AND FOLLOW-UP ACTIVITIES**

On July 22, 2002, your Board instructed the Department to test the water supplies of all DHS hospitals and the Hall of Administration for Legionella. Despite the positive results at some facilities, we do not believe there are significant risks to patients or others utilizing the water. DHS Acute Communicable Disease control staff is working with the facilities to minimize future risk and perform appropriate levels of surveillance. The table below summarizes the final results:

Facility	Status	Results
Hall of Administration	Testing Complete	4/5 samples tested positive for *Legionella pneumophila*: ▪ serogroup 6
Olive View	Testing Complete	7/7 samples tested positive for *Legionella pneumophila*: ▪ serogroup 6
Women's Hospital	Testing Complete	4/5 samples tested positive for *Legionella pneumophila:* ▪ 3 samples (serogroup 1) ▪ 1 sample (serogroup 4)
LAC+USC	Testing Complete.	11/11 samples tested negative
MLK*	Testing Complete	6/6 samples tested negative
Harbor/UCLA*	Testing Complete	10/10 samples tested negative
Rancho	Testing Complete	7/10 samples tested positive for *Legionella pneumophila*: ▪ 6 samples (serogroup 6) ▪ 1 sample (serogroup 1)
High Desert	Testing Complete	4/4 samples tested negative
* Indicates monochloramination disinfection of water		

Hospital Disease Surveillance

Infection control practitioners (ICP) from each county hospital were contacted and sent copies of the final laboratory results from the water samples.

Acute Communicable Disease Control (ACDC) staff have contacted the infection control practitioners (ICPs) at each of the hospitals to discuss surveillance activities. All DHS hospitals have existing surveillance activities for nosocomial infections. ACDC reviewed infection control programs and policy/procedures manuals at each hospital and found that these protocols meet Centers for Disease Control and Prevention Guidelines for the Prevention of Nosocomial Pneumonia (MMWR, January 3, 1997) and JCAHO 1994 Accreditation Manual for Hospitals.

ACDC has completed a written set of recommendations for all the county medical facilities (Attachment One). They have been reviewed by the California Department of Health Services and we previously received input from the representative of the federal Centers for Disease Control and Prevention who consulted with us. The recommendations clearly explain the surveillance and maintenance steps that we have discussed with each facility and which they are implementing.

To monitor implementation of our recommendations, all county hospital ICPs are being asked to provide quarterly reports on the number of Legionella diagnostic tests ordered for pneumonia. These diagnostic tests include: sputum cultures for Legionella, serum serologies, and urine antigens. ACDC will audit reports of positive legionella tests top verify that all cases have been reported as required by State regulations.

Facility Related Activities and Recommendations

Environmental Health staff met with facility managers from the hospitals and Hall of Administration to discuss issues concerning potable water, plumbing, heating, cooling and related systems.

On August 8, 2002, Environmental Health staff met with representatives of ISD and Hall of Administration facility management, Olive View, LAC/USC, KDMC and Harbor/UCLA. Topics discussed included: (1) evaluation of the facilities and facility plumbing structures; (2) issues regarding water temperature; and (3) recommendations to reduce Legionella in potable water systems.

Environmental Health reviewed with the facilities recommendations regarding:

- Addition of biocides to all cooling towers in addition to whatever anti-scaling/corrosive agents are presently being used.

- Review of water systems to identify dead legs, showers, and critical areas such as operating and post-operative rooms where the most susceptible individuals might be located to determine if there are ways to minimize the presence of stagnant water at tepid temperatures.

- Examination of the feasibility of installing tempering valves at every fixture so that the temperature of the hot water can be elevated to an appropriate level.

EH will reconvene a meeting with the facilities to review progress with these recommendations.

Hall of Administration

On August 15, 2002, ACDC staff met with SEIU Local 660 shop stewards from the Hall of Administration and Rhonda Albey, of the CAO employee relations. The meeting included a discussion the results of the water testing and any recommendations regarding the water system maintenance and operation. In addition ACDC physicians addressed clinical questions regarding the diagnosis of Legionnaires' disease.

Reporting of Communicable Disease Incidents

We have revised the protocols for reporting of Public Health incidents following the disclosure of Legionella cases at Good Samaritan Hospital. The revised procedures will assure more timely reporting to the Director of Health Services, the Director of Public Health, and the Board Offices. Whenever there is a situation which is likely to attract media attention, we will notify your Offices both via e-mail and telephone. Staff has been directed to implement these additional procedures immediately.

ACDC has been directed to provide weekly reports to us of all suspected outbreaks under investigation. In addition, when an incident meeting Departmental criteria for a reportable incident occurs, we are contacted immediately. Based on these reports or verbal communication for emergent issues, we consult with staff and determine which outbreaks require Board notification and, of these, which also require public notification. A description of our communicable disease notification procedures is included in Attachment Two.

We will update you as additional information becomes available or if further actions are warranted. In the meantime, if you have any questions, please let us know.

TLG:aml
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c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

ATTACHMENT ONE

GUIDELINES FOR THE PREVENTION OF NOSOCOMIAL LEGIONNAIRES' DISEASE

Background

In response to the recent nosocomial Legionnaire's Disease (LD) outbreak at Good Samaritan Hospital in Los Angeles, the Los Angeles County (LAC) Board of Supervisors (BOS) directed Thomas Garthwaite, MD, Chief Medical Officer, and Jonathan E. Fielding, MD, MPH, Health Officer LAC, to conduct water sampling and culturing for *Legionella species* at all 6 LAC Department of Health Services (DHS) hospital facilities and one county office building, the Hall of Administration.

Three of the six DHS hospital facilities and the one county office building sampled grew *Legionella pneumophilia* from their water systems. The water supplied to these facilities include: chlorinated water provided by Los Angeles Department of Water and Power (DWP), mono-chloraminated water, and non-chlorinated and chlorinated well water.

This document has been prepared by the Acute Communicable Disease Control Unit (ACDC) LAC DHS and reviewed by the State of California Department of Health Services to provide guidelines for the prevention of LD in DHS medical facilities. The risk of developing community acquired LD from public buildings where *Legionella* sp. have been recovered from potable water is unknown. This bacterium has frequently been present in water systems of buildings and hospitals without being associated with known cases of disease. It has also been isolated from environmental sources (plumbing systems, cooling towers) where outbreaks and sporadic cases have been confirmed. Therefore, this document will provide recommendations for only LAC DHS medical facilities.

Pre-emptive Culturing of Water

Pre-emptive culturing of water from hospitals without reported Legionnaires' Disease (LD) cases is considered primary prevention of LD. Sample collection, site of collection, number of specimens collected, and time of collection all can affect the results. No published recommendations are available for the prevention of community acquired LD or strategies for dealing with positive environmental cultures of *Legionella* species in non-hospital settings in the absence of LD cases.

From January 2001 through June 2002, no cases of nosocomial LD have been reported to ACDC from any DHS hospitals.

The prevention of LD in hospitals with no nosocomial identified cases (primary prevention) remains controversial. The Centers for Disease Control and Prevention (CDC) outlines two prevention strategies:

1. Routine periodic culturing of water samples from the hospital's potable water system for the purpose of detecting *Legionella* species; and

2. Maintain a high index of suspicion for LD among all nosocomially acquired pneumonia, especially in individuals at high risk for this disease, and pursue an environmental investigation upon confirmation of one definite case or two probable cases.

The CDC has generally recommended that the second strategy be followed. In contrast to the CDC guidelines, the Allegheny (PA) County Health Department has recommended routine environmental cultures of the hospital water supply since 1986, so as to screen for the possibility of occult LD in the hospital. When ≥ 30% of the samples from the hospital's potable water system are culture-positive for *Legionella* sp., the hospital's potable water system is decontaminated, and diagnostic laboratory tests for LD are made available for clinicians in the hospital laboratory so active case surveillance can be implemented. **It is to be noted that the 30% action level for potable water mitigation and enhanced LD surveillance is based on data collected by Allegany County Public Health Department which has not been replicated outside this county.** This approach is based on the premise that no cases of nosocomial LD can occur only if *Legionella* sp. is not present in the potable water system, and conversely, if *Legionella* sp is cultured from the water system, cases of nosocomial LD could occur. They feel this approach has resulted in a 50% decrease in nosocomial LD. The main argument against this approach is that, in the absence of cases, the relationship between water cultures and the risk for LD remains undefined.

It should also be recognized that none of the LAC DHS hospitals currently perform bone marrow or solid organ transplantation, which is a well established risk factor for LD. The CDC endorses environmental surveillance for *Legionella* sp. for facilities performing bone marrow and solid organ transplants and subsequent water remediation efforts when *Legionella* sp. is cultured from the potable water.

Recommendations for Prevention

The objective of *Legionella* prevention is not elimination of *Legionella* in water systems, but ensuring the absence of conditions that foster amplification of bacteria that lead to disease transmission.

All Medical Facilities – Regardless of Water Culture Results

In addition to routine hospital and building plumbing/environmental maintenance, the following standards should be followed by all medical facilities, regardless of water culture results:

1. Clinicians should be educated to heighten their suspicion for cases of nosocomial and community acquired LD and use appropriate methods for its diagnosis and treatment.

2. Appropriate diagnostic tests should be submitted when the diagnosis of LD is considered. Patients in whom LD is considered should have a sputum culture and a urine antigen test performed. Hospital clinical microbiology laboratories should have the capability of culturing for *Legionella* sp., which requires selective media. Sputum cultures positive for *Legionella* sp. should be sent to the LAC Public Health Laboratory for confirmation and serogrouping. For some clinical microbiology laboratories, direct visualization of the bacterium in respiratory secretions or tissue by immunofluorescent microscopy may also be feasible as an additional more rapid diagnostic approach. Urinary antigen screening but will only detect *L. pneumophila* serogroup 1. Testing paired sera for *Legionella* antibodies (acute and convalescent sera 3 to 4 weeks apart) is appropriate for surveillance but is not useful for the acute diagnosis.

4. The LAC Public Health Laboratory should serve as a reference laboratory for *Legionella* species, with the capability of serotyping, species identification, and molecular characterization of isolates.

5. Use the CDC case definition to determine whether the Legionella pneumonia case is nosocomially or community acquired.

    a. Definite nosocomial case: Laboratory confirmed diagnosis and patient hospitalized continuously for 10 days before onset of Legionella infection.
    b. Possible nosocomial case: Laboratory confirmed diagnosis and patient hospitalized 2 – 9 days before onset of Legionella infection.

6. In hospital facilities with more than one case of laboratory-confirmed nosocomially acquired LD within a 6 month period, should initiate, in conjunction with ACDC and DHS Environmental Health, a thorough epidemiologic and environmental investigation.

7. Nebulizers and other semi-critical respiratory care equipment should be cleaned with sterile water and maintained according to manufacturer's recommendations.

8. Water placed in nasogastric tubes for feeding or flushing should be bottled or sterile water.

9. Hospital units with high-risk patients should not use large volume humidifiers that create aerosols unless they are sterilized with a high level disinfectant daily and maintained according to manufacturer's recommendations.

10. All community acquired and nosocomial LD cases should be reported to ACDC within 7 calendar days, as required by California Code of Regulations, Title 17, section 2500.

11. To reduce the possibility that *Legionella* species may amplify in the potable water system, facilities maintenance personnel should:

    - Maintain cold water storage and distribution systems at temperatures below 20 degrees C (68 degrees F0 when possible.
    - Hot water should be stored above 60 degrees C (140 degrees F) and be circulated with a minimum return of 51 degrees C (124 degrees F).
    - Follow the California Code of Regulations: Title 22, §70863 (d) that states for hot water used by patients, there shall be temperature controls to automatically regulate the temperature between 40.5 degrees C (105 degrees F) and 48.9 degrees C (120 degrees F). This implies that a higher continuous circulating temperature is permitted as long as the temperature at the tap is controlled with preset thermostatic mixing valves regulated to deliver hot water between 40.5 and 48.9 degrees C.
    - Be familiar with Plumbing Code, Title 24, part 5.
    - Maintain hot water free chlorine residuals at 1-2 mg/L (1-2 ppm) at the tap and the pH level between 7-8/
    - Develop a contingency plan for municipal water disruption.
    - Periodically clean showerhead and facet aerators.
    - Periodically clean hot water storage tank, ice machines and equipment that filters potable water such as endoscope reprocessors
    - Follow manufacture's recommendations for cleaning equipment.

- Keep accurate records.

12. Health facility maintenance engineers and infection control personnel should be familiar with American Society of Heating, Refrigerating and Air-conditioning Engineers (ASHRAE) Standard Guideline 12-2000, "Minimizing the risk of Legionellosis associated with Building Water Systems", as a guideline endorsed by the Centers for Disease Control and Prevention as well as the State of California Department of Health Services, as a guideline to provide information and guidance to minimize risk of disease transmission from building water systems.

For medical facilities where *Legionella sp*, was isolated, additional measures should be considered:

1. Infection control committees should consider additional surveillance policies targeting nosocomial LD as an important preventable cause of nosocomial pneumonia. They should address how to increase the sensitivity of their surveillance system to detect increases in nosocomial pneumonia on any nursing unit especially among patients with established LD risk factors, including chronic lung disease, cancer, kidney failure requiring dialysis, diabetes, AIDS, and chronic immune suppression drugs. In addition, surveillance should be considered for individuals who are readmitted to a hospital within a 72 hour period with a diagnosis of pneumonia.

2. Future environmental surveillance for *Legionella sp*, within the water distribution systems in the hospital should be determined by an individual risk assessment of the institution. The risk assessment process should consider both institutional risk factors and remediation efforts. The risk factors are defined by: building engineering specifics (age of building, complexity, sedimentation, number of host water systems); patient mix (solid organ transplant, bone marrow transplant, cancer patients undergoing chemotherapy, COPD); prior history of LD identified among patient within the institution; and history of positive water cultures from the potable water system and outlets or cooling towers.

References

1. Guidelines for the Prevention of Nosocomial Pneumonia. *MMWR*. January 3, 1987, Vol. 46, pp. 28-34.
2. Approaches to prevention and control of Legionella Infection in Allegheny County health care facilities. Allegheny County Health Department. January 1997.
3. Butler JC, Breiman RF. Legionellosis. From Evan AS, Bracnman PS, ed. Bacterial Infections of Humans; Epidemiology and Control, 3rd ed. New York: Plenum Publishing Corp.
4. Yu VL. Nosocomial legionellosis. *Current Opinion in Infectious Diseases* 200; 13:385-388.
5. Report of the Maryland Scientific Working Group to study Legionella in the water systems in Healthcare Institutions. State of Maryland Department of Health & Mental Hygiene. June 14, 2000.
6. Rosenberg, J. Nosocomial Legionellosis. California Department of Health Services Public Health Grand Rounds, January 25, 2001.
7. Kool JL, Fiore AE, Kioski CM, et al. More than 10 years of unrecognized nosocomial transmission of Legionnaires' disease among transplant patients. *Infec Control Hosp Epidemiol* 1998; 19: 898-904.

8. Lepine LA, Jernigan DB, Butler JC, et al. A recurrent outbreak of nosocomial Legionnaires' disease detected by urinary antigen testing: evidence for log-term colonization of hospital plumbing system. *Infec Control Hosp Epidemiol* 1998; 19: 905-910.
9. Yu VL. Resolving the controversy on environmental cultures for *Legionella*: a modest proposal. *Infec Control Hosp Epidemiol* 1998; 19:893-897.
10. American Society of Heating, Refrigerating and Air-conditioning Engineers (ASHRAE) Standard Guideline 12-2000, "Minimizing the risk of Legionellosis associated with Building Water Systems", February 5, 2000.

Notification Regarding Communicable Disease Events

The following provides and overview of the Departments revised notification procedures regarding communicable disease events.

Notifications regarding communicable disease events within the Department are communicated via two mechanisms: Critical Incident Reports and Acute Communicable Disease Control (ACDC) Outbreak Summary Logs.

Critical Incident Report

Public Health Policy No. 110 directs staff to notify Public Health and DHS executives in the event of a variety of critical or sensitive public health issues, including communicable disease cases that are considered highly sensitive or critical in nature. A copy of the report form and policy is attached. The Policy:

- Establishes procedures for notifying the Director of Public Health and Health Officer and the Director of Health Services regarding critical or sensitive public health issues.
- Ensures that notification occur rapidly, during business hours, after hours and weekends and holidays.
- Is faxed immediately to the Director of Public Health, Chief of Operations, Director of Health Services, Chief of Operations Public Health and Chief Deputy County Counsel are notified via a faxed form.
- Indicates that Board offices are notified depending on the nature and severity of the incident reported.

To assure awarenèss and understanding of the Critical Incident Report we re-distributed the policy to staff and posted it prominently on our Public Health Intranet.

ACDC Outbreak Summary Log

ACDC e-mails weekly a log summarizing all on-going outbreaks and disease investigations. The log:

- Provides a weekly summary of all significant assignments and problems under investigation
- Is sent to the Public Health Medical Director, Director of Public Health/Health Officer, Director of Department of Health Services.
- Ensures that Public Health and DHS executive staff is aware of all on-going disease investigations.

Situations under investigation reported in the Outbreak Summary Log may also be reported via the Critical Incident Report if indicated.

Notification Guidelines

Guidelines for notification of parties outside of the Department regarding communicable disease outbreaks have been developed to assure that appropriate parties are made aware of these events. The guidelines include the following disease/outbreak criteria to evaluate the situation and determine the appropriate parties to be notified:

- Widespread cases or exposures
- Significant morbidity and/or mortality
- Unknown mechanisms of transmission, pending ACDC investigation
- Media inquiring originating independent of DHS activity
- Likely to become a media subject with request for DHS comment

Procedures for Notification

- **Notifying the Medical Director:** ACDC staff consult with Medical Director regarding unusual case(s) of communicable disease, suspected outbreak or widespread illness.

- **Notifying the Public Health Director/Chief of Operations:** Following receipt of information (via critical incident report, outbreak summary log or e-mail or verbal communication) the Medical Director consults with the Director of Public Health/Chief of Operations.

- **Notifying the DHS Director/Chief of Operations:** Public Health Director/Chief of Operations notify (verbally or via e-mail) the DHS Director /Chief of Operations of the communicable disease event. Additional consultation with ACDC staff and Public Health Medical Director may be needed.

- **Notifying the Board of Supervisors:** Depending on the specifics of the event, one or more Board Offices may be notified verbally, via e-mail or via memo. In cases of widespread or very serious events, all Board offices will be notified both via e-mail/memo and telephone.

- **Notifying the Media:** Following notification of the Board, the news media may be notified if their assistance is needed in notifying the public or health professionals. Frequently the news media approaches the Department to confirm or obtain addition information regarding disease outbreaks, cases or other public health threats. Following consultation with the Director of External Relations, DHS and Public Health executive staff will determine if media disclosure is warranted. If press and public notification is warranted a health advisory will be released and disseminated. Releases may target an impacted geographical area or may be countywide.

- **Notifying the Public:** ACDC staff working with the DHS Communications Office and other programs, as needed, will develop and implement efforts to inform the public about an on-going public health event. The mechanism and scope of this notification will depend upon the specifics of the situation. In addition to health advisories, web postings, letters, onsite postings and communication with professional organizations may be used to provide information to the public or impacted segment of the public.

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

SUBJECT: REPORTING CRITICAL OR SENSITIVE PUBLIC HEALTH ISSUES

POLICY NO: 110

PURPOSE: To establish procedures for notifying the Director of Public Health and Health Officer and the Director of Health Services regarding critical or sensitive public health issues.

To ensure that such notifications occur rapidly, both during business hours and after hours, including weekends and holidays.

To ensure that Public Health (PH) Executive Team members and all PH staff are familiar with reporting mechanisms and with the criteria for reporting critical or sensitive issues.

PRINCIPLES: The protection of the health of the public requires timely and accurate reporting of public health issues to the Director of Public Health and Health Officer.

The ability of the Director of Public Health and Health Officer to report critical or sensitive public health issues to the Director of Health Services and the Board of Supervisors depends on timely reporting by Public Health staff and the Executive Team members.

DEFINITION: Critical or sensitive public health issues are those that have the potential to significantly affect the health of the public, involve large-scale mobilization of staff or services, impose liability, involve multiple jurisdictions, or attract media attention. Examples include disease outbreaks, environmental threats, food contamination, staffing shortage and service interruption, thefts or damage at facilities, visits by dignitaries, or any event, which in the reporter's opinion, merits immediate communication to the Director of Public Health and Health Officer.

NOTE: Depending on circumstances, report events using either Reportable Incidents – Non-Clinical Event or the Critical Clinical Event forms (attached) or by telephone.

Some incidents may attract media attention. In such cases, contact the appropriate, available manager, the Public Health Chief of Operations, or Director of Public Health and Health Officer, and the DHS Office of Public Information prior to committing to an interview. Refer to PH Policy 113, "Contact with News Media," and PH Policy 113.1, "Release of Confidential Information."

PROCEDURES:

A. For PH facility, program and unit staff and administrators/managers:

1. Notify the supervisor immediately by telephone. If the supervisor is not available, notify the supervisor at the next level.

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

SUBJECT: REPORTING CRITICAL OR SENSITIVE PUBLIC HEALTH ISSUES **POLICY NO.:** 110

PROCEDURES:

B. For PH facility, program and unit staff and administrators/managers:

1. Notify the supervisor immediately by telephone. If the supervisor is not available, notify the supervisor at the next level.

2. After hours, on weekends or holidays, if the supervisor is unavailable, call the County Operator at (213) 974-4321. County Operators have lists of senior DHS and PH staff that include home, cellular, and pager numbers. If callers do not ask for specific individuals, the County Operator will have calls returned by the PH Administrative Officer of the Day (AOD), or by the Environmental Health officer on-call.

3. If indicated, complete the appropriate form, according to instructions.

C. For PH Executive Team

1. Immediately notify the PH Chief of Operations by telephone.

2. If the Chief of Operations is not available, notify the Director of Public Health and Health Officer.

D. For Director of Public Health and Health Officer and PH Chief of Operations

1. Notify the DHS Chief Operating Officer and the Director of Health Services if the issue is critical or sensitive.

2. If indicated, notify the Board Health Deputies by telephone or in writing.

3. If indicated, activate an incident response team to ensure a coordinated response.

REFERENCES: DHS Policy Nos. 311, "Incidents Involving Potential Claims Against the County"
311.1, "Medical Device Reporting Program"
311.2, "Critical Clinical Event (including Sentinel Event) Reporting and Follow-up
360-366, Various policies on confidentiality of records
PH Policy Nos., 113, "Contact with News Media"
113.1, "Release of Confidential Information"

EFFECTIVE DATE: 03/31/02

SUPERSEDES: 02/02/00

REPORTABLE INCIDENTS – NON-CLINICAL EVENTS

Directions: Check the appropriate box, fill in the information section. Immediately FAX the completed form to Fred Leaf, Chief Operating Officer, Department of Health Services, at (213) 482-1026; Gary Miller, Principal Deputy County Counsel, at (213) 687-7337; Jonathan E. Fielding, M.D., M.P.H., Director of Public Health and Health Officer at (213) 975-1273 and John F. Schunhoff, Ph.D., Chief of Operations, Public Health, at (213) 481-2739.

Staff Related Incidents

- ☐ Allegations of improper supervision
- ☐ Jail/custody cases (civil rights violations)
- ☐ Unlicensed staff performing procedures
- ☐ Staff sexual misconduct
- ☐ Safety Police weapons discharges
- ☐ Injuries caused by Safety Police
- ☐ Suicides
- ☐ Fraud/misappropriation
- ☐ Suspected work actions
- ☐ Serious allegations against staff
- ☐ Severe staff shortages
- ☐ Serious injury/death

Facility/Equipment Related Incidents

- ☐ Interruptions in service
- ☐ Major facility damage
- ☐ Significant disturbances (e.g., bomb threats, civil unrest, protests)
- ☐ Major thefts
- ☐ Equipment malfunction
- ☐ All agency inspections

Miscellaneous Incidents

- ☐ Incidents reportable to the State/others
- ☐ Disasters
- ☐ Unusual and recurring patient complaints
- ☐ VIP as patients
- ☐ VIP visitors
- ☐ Unspent grant funds
- ☐ Unusual media attention
- ☐ CAL-OSHA violations/inspections
- ☐ SCAQMD violations/inspections
- ☐ Bioterrorism incidents
- ☐ Hazardous exposures/releases
- ☐ Other

INFORMATION

Facility/Unit(s): _____ Date: _____ Time: _____

Report prepared by: _____ Phone: _____

Responsible Manager: _____ Phone: _____

Is a Board Memo being prepared? ☐ Yes ☐ No If yes, when will it be sent: _____

Describe the incident: _____

Action Taken: _____

Follow-up action planned: _____

Director comments: _____

Follow-up assigned to: _____ Reporting Frequency: _____

Note: Please attach a second page or other supportive information as appropriate.

CONFIDENTIAL – DO NOT COPY

Attorney/Client Protected Information

JFS:lc
Revised 3/31/02

CRITICAL CLINICAL EVENT REPORTING FORM

CONFIDENTIAL: *Some information contained in this document is privileged and strictly confidential under state law, including Evidence Code sections 1157 and 1157.7 relating to medical professional peer review and Government Code section 6254 relating to personnel records.*

Directions: Check the appropriate box and fill in the information section. Immediately FAX the completed form to Thomas L. Garthwaite, M.D., Director of Health Services and Chief Medical Officer at (213) 481-0503.

Critical Event: an unexpected occurrence that requires immediate investigation in the Medical Officer or Risk Manager's judgment.

- ☐ Admission as a result of an adverse occurrence in the outpatient setting
- ☐ Development of a neurologic deficit not present on admission
- ☐ Unplanned removal of an organ during surgery
- ☐ Pathology/Tissue mismatch resulting in undiagnosed cancer or delay in diagnosis of cancer
- ☐ Adverse blood reaction resulting in death or permanent disability
- ☐ Adverse blood reaction resulting in a permanent disability
- ☐ Unanticipated death
- ☐ Unanticipated neonatal death
- ☐ Maternal death
- ☐ Birth trauma (i.e., erb's palsy)
- ☐ All birth/brain injuries (e.g., diagnosis of hypoxicischemic encephalopathy, seizures in the nursery, apgars <5 at 5 minutes
- ☐ Unanticipated medical and/or surgical complications causing disability
- ☐ Patient suicide
- ☐ Jail/custody cases (e.g., alleged civil rights violations, alleged discrimination)
- ☐ Procedures performed by unlicensed staff
- ☐ Mistaken amputations
- ☐ Staff sexual misconduct with a patient
- ☐ Major disease outbreaks
- ☐ Bad outcome after a procedures (e.g., coma, spinal injury, blindness)
- ☐ Food recalled by DHS
- ☐ Unplanned foreign bodies left in patients
- ☐ Unplanned nerve damage related to a medical/surgical procedure
- ☐ Significant patient dissatis faction
- ☐ Medical/surgical intervention on the wrong patient
- ☐ Accidental burns
- ☐ *Intra* facility transfers resulting in disability or death
- ☐ *Inter* facility transfers resulting in disability or death
- ☐ Other significant clinical events that may subject the Department of Health Services to adverse publicity or liability
- ☐ Significant equipment related injury
- ☐ Other: _____

Information

Facility designated tracking number _____

Facility/Unit(s): _____ Date: _____ Time: _____

Report prepared by: _____ Phone: _____

Was Octagon Risk Services (ORS) notified? ☐ Yes ☐ No Has a Board Memo been prepared? ☐ Yes ☐ No

Describe the critical event. Provide as much information as is currently known, even if only a partial report can be given.

_____

_____

Action Taken: _____

_____

Follow-up action planned: _____

_____

_____

Follow-up

ADCMA's Comments: _____

_____

Follow-up assigned to: ☐ Facility Medical Director ☐ Quality Improvement Program ☐ Other: _____

po110att
revised 03/31/02